Please fill out and return on the date of your appointment_____, Thank You

Patient Information

Date_____

Patient's Name_____
First Middle Initial Last Nickname

Address_____
Street City State Zip

Age____Birthday_____Sex____Home Phone_____Work Phone_____

If Patient is a minor, give parent's or guardian's name_____

Phone_____

Responsible Party Information

□ Patient
□ Parent Name_____
□ Guardian First Middle Initial Last DOB

Address_____
Street City State Zip

No. of Years at this address_____Home Phone_____Work Phone_____

Social Security #_____Relationship to Patient_____

Employer_____Occupation_____No. Years Employed____

Spouse's Name_____
First Middle Initial Last D.O.B.

Address_____
Street City State Zip

Spouse's Employer_____No. Years Employed_____

Social Security #_____Occupation_____Work Phone_____

Insurance Information

Insured's Name_____Insured's Soc. Sec. #_____D.O.B.____

Dental Company_____Group No._____Phone #_____

Address_____

Do you have dual coverage Yes□ No □ if yes: complete second party information below.

Insured's Name_____Insured's Soc. Sec. #_____D.O.B.____

Dental Company_____Group No_____Phone #_____

Address_____

Emergency Information

Name of nearest relative or friend not living with you_____

Complete Address_____

Phone_____Relationship to Patient_____

Signature (Parent's signature if minor)_____

Dental History

Family Dentist_____ Phone_____ Last Visit_____

Address_____
Street City St Zip

Previous Orthodontic Treatment Y N Orthodontist_____

Dental or Facial Truma_____

Finger Habits_____ Mouth Breathing_____ Speech Problems_____

Pain ◻ Yes ◻ No Jaws Neck Shoulder Head Face
(is yes: circle location)

Patients Chief Concern_____ Parents Chief Concern_____

Medical History

Operations: Tonsils ◻ Y ◻ N Adenoids ◻ Y ◻ N Other:_____ Patients M.D._____
Name & Number

Serious Illness (circle): Heart Trouble, Rheumatic Fever, Diabetes, Epilepsy, Kidney/Liver involvement
Gland or bleeding disorder, Childhood diseases, Other:_____

Presently Under Medical Care? ◻ Y ◻ N For What:_____ Hgt:____ Weight:____

Presently Taking Any Medications? ◻ Y ◻ N What Medicine_____ Contacts ◻ Y ◻ N

Allergies_____ Drug Reactions_____

Comments on Medical History:_____

Authorization

I the undersigned have given the above dental and medical information, have reviewed it and find it accurate. If there are any later changes to this history record, I will so inform this practice.

_____ _____
Signature (patient/responsible adult) Date

This information has been reviewed with the above named individual.

_____ _____
Signature Position Date

How did you first become aware of your need
For orthodontic treatment_____

Who can we thank for
Referring you to our office _____

Siblings
In Family: Name/Age 1)_____ 2)_____ 3)_____ 4)_____ 5)_____

Siblings in TX
Or treated here: 1)_____ 2)_____ 3)_____ 4)_____ 5)_____

Notes

_____

_____

_____